24 February 2007

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News: OFT demands better value from branded drugs

News: DH sets out plans for professional regulation

Features: Are you ready for access to patient records?

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Pharmacy Champions

Cover: This week's Pharmacy Champion, Jonathan Lloyd. Picture: Pacemaker Press

Historic regulatory reforms thrust pharmacy into bold new era

Policy White Paper sets out vision of General Pharmaceutical Council and Royal College

Tom Hawkins

Dramatic changes to the way pharmacists, pharmacy technicians and pharmacy premises in the UK will be regulated in the future have been unveiled by the government this week.

In a White Paper released on Wednesday, the Department of Health revealed that the RPSGB's potentially conflicting dual role should be clearly separated.

Regulation, including the revalidation of pharmacists, will be managed by an appointed General Pharmaceutical Council (GPC). This independent body, which could be in place as early as 2010, will comprise a minimum of 50 per cent lay membership and will be answerable only to government.

The White Paper suggests that clinical and professional representation should be handled separately by a Royal College, which will liaise with the GPC on matters such as standards and undergraduate education. It will also play a role in pharmacist revalidation.

A Society spokesperson said: "If a separate GPC is established, we would want to see the Society evolve into a Royal College." It is thought that this would require amendments to the existing Royal Charter or an entirely new charter. Senior members of the Society, including president Hemant Patel, were locked in talks at the Department of Health as C+D went to press.

Keith Ridge, chief pharmaceutical officer for England, said pharmacy was entering the 'premier league' of healthcare and that it was necessary to embrace the regulatory model used by professionals such as doctors and nurses. "There's a lot more hands-on clinical care. It's beginning to happen and it will be immense in the future. At that point pharmacy needs to sit alongside other healthcare professions," he said.

A working party led by Lord Carter of Coles will negotiate details of the GPC and Royal College with pharmacy groups and key stakeholders. It will report its initial recommendations to ministers by March 31. Legislation for the GPC is expected to be in place by mid 2008.

The Pharmaceutical Society of Northern Ireland and DHSSPSNI are in negotiations over being integrated into the wider UK scheme.

The radical changes set out in the White Paper – Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century – form part of a wider DH approach to safeguard patients and demonstrate independent regulation of healthcare professionals.

Its publication coincides with the government's response to the Fifth Report of the Shipman Inquiry and the release of an overview of the actions it is taking following the Shipman reports, entitled Learning From Tragedy, Keeping Patients Safe.

The role of the GPC

Independent of government.
Led by an equal partnership of professional and lay members.
Make judgments based on a civil not criminal standard of proof.
Revalidate pharmacists on a regular basis.

Feedback

The DH invites comments from pharmacy stakeholders about the White Paper proposals. Contact Diana Kenworthy at 4th floor, Skipton House, 80 London Road, London or email diana.kenworthy@dh.gsi.gov.uk

The RPSGB response

"Any new arrangements must bring improved patient safety and stronger professional leadership for pharmacists. The transition to a General Pharmaceutical Council and the possible establishment of a body akin to a Royal College must be properly managed and resourced.

"We want to see full consultation with the profession and with others who have a key stake in the Society's work. And, of course, the dedicated and skilled staff of the RPSGB must be fully considered and consulted during the process of any change."
RPSGB president Hemant Patel

Your views

On the RSPGB:

"The RSPGB should only be in charge of professional matters, I've no time for the Society at all.

"The break-up of the Society has been coming for a long time."
Mike Long, Highbury Pharmacy, London

"It's [the break up of the RPSGB] a good idea. It would be nice to have a body that represents our interests rather than punish us all the time. I've been a member of the Society for 23 years and I've never felt they've represented me."
Chris Babbs, acting area manager south west, Day Lewis Pharmacy, Devon

On revalidation:

"I'm afraid the government might find an exodus. Quite a few people can't be bothered with all this because they've been on the register for a while. This is a fear in the hearts of all pharmacists.

"I can understand the need for it but I think it's too much. We already have to deal with the new contract. This will put a lot of people off. They might digress to other careers."
Shenu Barclay, Old Coulsden Pharmacy, Surrey

Mike Long of Highbury Pharmacy, London (right): "The break-up of the Society has been coming for a long time"

News in brief

Don't miss

Cardiovascular risk and respiratory disease are under discussion at a series of C+D/National Prescribing Centre workshops this March. The events, which contribute to pharmacists' CPD, will be held on March 13 in Leeds and Warwick on March 20. To ensure a place, book early on 01732 377269 or see p35.

GSK gets drug rights

GSK has acquired the rights to market an over the counter formulation of the weight loss treatment orlistat in countries across the world, apart from the USA and Japan. The company expects to make an application for a licence to sell orlistat OTC in Europe during 2007. The FDA granted approval to market OTC orlistat in the USA under the brand name Alli in early February.

'80pc' sign up at Pfizer

Around 80 per cent of pharmacists have opened an account with Pfizer, just over a week before it launches its direct to pharmacy deal, the drug company has revealed. However, wholesaler AAH has claimed that less than 50 per cent of pharmacists have opened an account, following a telesales survey of 200 of its customers.

UniChem will become the sole distributor for Pfizer from March 5.

Pillow talk: Lord Hunt reveals all about life in the pharmacy hot seat in a C+D exclusive next week

Lord Hunt plans to bridge divide

Exclusive Pharmacy minister intends to bring pharmacists and GPs together

Pharmacy minister Lord Hunt has pledged to build bridges between pharmacists and GPs ahead of practice-based commissioning.

In an exclusive interview with C+D Lord Hunt said: "I think our role must be to do what we can to encourage more contact. I am certainly happy to talk to both GPs and pharmacists about this to see if there is anything further we can do to encourage it."

Speaking out for the first time since taking the top job this January Lord Hunt told C+D he was "glad to be back" as pharmacy minister and the profession had "broken barriers" since he last held the post in 2003.

"Coming back to the job and the new contract you just know that this is a profession that has been given a great opportunity to use its skills in the future," he said. **CB**

"I know there will be issues about us not going fast enough, but it does seem to me we have momentum." Lord Hunt speaks out in our exclusive interview next week. Don't miss it.

OFT proposes radical drug pricing overhaul

Medicines Proposals would link the cost of branded medicines more closely with value they bring to patients

Tom Hawkins and Gavin Atkin

Drug manufacturers and pharmacies face radical changes in the pricing of pharmaceutical products if the government accepts proposals contained in a major report from the Office of Fair Trading.

The report discusses several options, but prefers a proposal for the price of branded drugs to be decided by a formula based on Quality Adjusted Life Years measurements compared with other treatments.

The calculations would become part of the technology appraisals carried out by Nice and the SMC, and would be fast-tracked to allow drugs to be made available quickly.

Where the data required for the calculation was unavailable, the OFT has suggested a risk-sharing mechanism in which the drug is reimbursed contingent on the benefit claims by the makers being met.

Also, off-patent branded 'originator' medicines would be taken out of the existing Pharmaceutical Price Regulation Scheme, and instead reimbursed at an enhanced Drug Tariff rate set at 25 per cent above the price paid for generic equivalents, where they exist. At a stroke, this proposal would eliminate brand equalisation deals in which suppliers offer discounts to pharmacies.

The detailed 114-page report estimates that its proposals to link the costs of branded medicines more closely with the value they bring to patients could have saved the NHS £500 million in 2005, and a further £65m could be cut by substituting off-patent brands with generics.

However, Simeon Thornton, leader of the OFT team that compiled the report, told C+D that pharmacy would be largely unaffected by the plans. The measures would encourage the pharmaceutical industry to target new areas of patient need in search of new profits, he added.

John Beighton, managing director of Teva UK and vice-chairman of the British Generic Manufacturers Association, said it was right that off-patent brands should be judged in the same way as generics. "We'd like to see more generics prescribed and dispensed as a result of the recommendations. It won't take money out, it will leave money in to be spent on higher cost medicines."

However, pharmaceutical companies refuted suggestions drug prices did not reflect good value. They also warned the Department of Health that adopting any wholesale changes could upset the existing stable environment provided by PPRS and could jeopardise investment.

Dr Richard Barker, director general of the Association of British Pharmaceutical Industry, said: "The system should continue to evolve, in our view, rather than be scrapped."

Professor Adrian Towse of the industry research organisation Office of Health Economics said manufacturers could look to shift their activities to emerging markets.

The government has 120 days to consider the proposals, which could be implemented as early as 2010.

Independent prescribing pioneers call for publicity

Practice Call for support to educate patients about new prescribing role

Living the dream: pharmacists celebrate achieving independent prescribing status at the University of Bath

Max Gosney

The first wave of independent prescribers in England has called for a national campaign to promote their skills to patients.

"I think we need national promotion. Many people still think of pharmacists as working in a shop. It's up to us to tell them about our new role," said Jane Coleborn, one of 26 pharmacists to be awarded independent prescribing status from the University of Bath this week.

"I think it would be a good idea to start the public debate," commented David Thompson, course graduate and pharmacist at Boots at Southbourne, near Bournemouth. "I would like to raise awareness among the public so that patients are not surprised when they discover I can prescribe," added Mr Thompson, who plans to use his qualification as part of a community addiction team.

Is enough being done to publicise independent prescribing? Contact C+D on 01732 377315 or email mgosney@cmpmedica.com

Course tutors expressed pride and optimism for the group of students now specialising in treatment areas including dermatology, hypertension and oncology.

"We really want them to go out there and live the dream in terms of pharmacy practice. I think this is a real opportunity to show what pharmacists can do," said Dr Andrea Taylor, director of taught postgraduate programmes at Bath.

However, students need wider support to make a success of their skills. She added: "I don't think there's been enough information for patients. We need something significant to get the message across and I hope the [Royal Pharmaceutical Society] is proactive in letting people know."

The 26 graduates include two community pharmacists. The majority of students work for PCTs or hospitals. The group enrolled as supplementary prescribing trainees in March 2006, then took a conversion course to achieve IP status.

Many of the graduates will return to offer advice to students on next year's course.

The 26-strong group join Beth Hird, who graduated from Keele University, as qualified independent prescribers. Five Northern Ireland pharmacists also achieved IP status last month.

£3,000 fine for application abuse planned

Legislation Proposals to offset £3m cost to NHS

Applicants putting in time-wasting bids to open a pharmacy face fines of more than £3,000 under a draft pharmacy application fee structure.

The proposals, Implementation of the Health Act 2006: Fees for Applications to Provide NHS Pharmaceutical Services in England, propose a raft of what ministers describe as "reasonable" pharmacy application charges.

These range from £150 for minor relocations under 500m, changes of ownership or conversions from preliminary to full consent (where there is no change in details) to £1,500 for a subsequent application within 180 days of an application failing.

The legislation also establishes a £3,000 'fine' for duplicate applications that have already failed.

The charge structure, which is part of the government's 'balanced package of measures' announced in response to the Office of Fair Trading inquiry into the pharmacy 'control of entry' regulations, was brought in as part of the Health Act 2006.

The primary aim of the charges is to save the NHS the estimated £3.12 million currently spent on processing NHS pharmacy applications.

Comments on the proposals should be sent by May 11 to gillian.farnfield@dh.gsi.gov.uk **AC**

Read about what's happening in European pharmacy. See p30

Pharmacists win OOH hotline

Practice Mobile solution to out-of-hours crisis

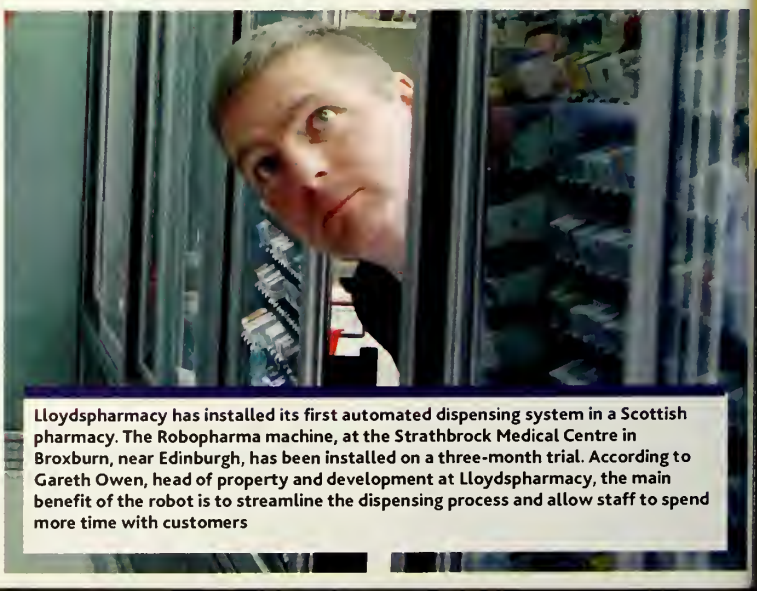
Pharmacists in Cornwall have scored a victory for their patients after the company providing out-of-hours care agreed to set up a direct mobile hotline between them.

Pharmacists spoke out after they were unable to contact Serco, the company contracted by Cornwall & Isles of Scilly PCT to provide OOH care.

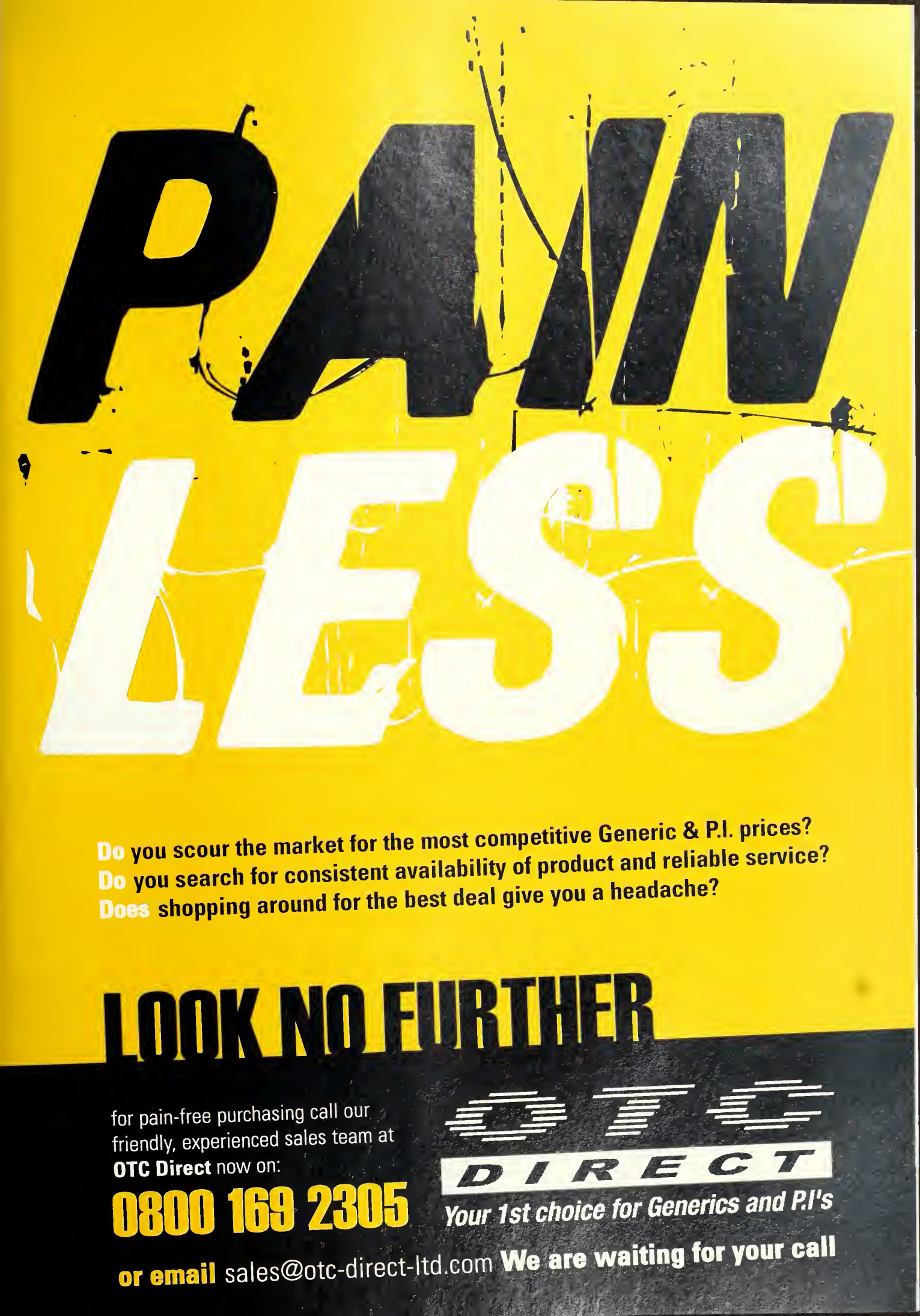
Robin Kay, chairman of Cornwall & Isles of Scilly LPC, said: "Pharmacists are extremely frustrated. As community pharmacists, they have a concern and familiarity with their patients which they build up over years."

Steve Moore, director of commissioning and strategic development at Cornwall & Isles of Scilly PCT, said: "The PCT is working closely with Serco to improve the service provided by the out-of-hours service.

"Following feedback from pharmacists, Serco established a dedicated telephone line and ... this has been supplemented with a mobile telephone number." **WYP**



Lloydspharmacy has installed its first automated dispensing system in a Scottish pharmacy. The Robopharma machine, at the Strathbrock Medical Centre in Broxburn, near Edinburgh, has been installed on a three-month trial. According to Gareth Owen, head of property and development at Lloydspharmacy, the main benefit of the robot is to streamline the dispensing process and allow staff to spend more time with customers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Campaigner has conviction upheld

Legal Judge says conviction 'necessary'

A woman who sent pictures of aborted foetuses to pharmacists has failed in a bid to overturn her conviction.

London's High Court ruled that Veronica Connolly, a Christian "pro-life" grandmother, had no right to cause distress to others who might see the pictures.

Mrs Connolly, 50, who is disabled with ME and uses a wheelchair, had asked the High Court to quash her conviction on the grounds that it violated her rights to freedom of speech and freedom of expression of her religion.

She was prosecuted under the 1988 Malicious Communications Act for posting photographs of aborted foetuses to pharmacies in Solihull, Birmingham, in a campaign against the morning-after pill.

Dismissing her challenge, Lord Justice Dyson said: "I would hold that it has been convincingly shown that the conviction of Mrs Connolly on the facts of this case was necessary in a democratic society.

"Her right to express her views about abortion does not justify the distress and anxiety that she intended to cause those who received the photographs." **UKL**

Welsh qualification universal

Wales Independent prescribers accepted in England

Fears that different training for independent prescribers in Wales will restrict professional movement into and out of England have been rejected by the Welsh government.

Welsh health minister Brian Gibbons will add a course on numeracy into the diploma which will be studied at Cardiff, Swansea, Pontypridd, Bangor and Wrexham.

A government spokesman said pharmacists training either side of the border would have their qualifications recognised in the other country and therefore be able to practise there.

A Cardiff University spokesman said: "The course in Wales has generally been seen to be most rigorous and exacting." **CB**

MUR numbers climb as pharmacists take action

Practice More than 4,000 contractors claim MUR payments for November 2006

Jane Ellis

Pharmacists are starting to get to grips with medicines use reviews, with more than 4,000 contractors in England claiming MUR payments in November 2006.

According to the latest figures from the NHS Business Services Authority, 63,455 MURs were carried out in November 2006. The cumulative total from April to November 2006 was 309,879, compared with 33,311 in the same period in 2005. More than £7 million has been claimed in fees to November 2006, according to PSNC.

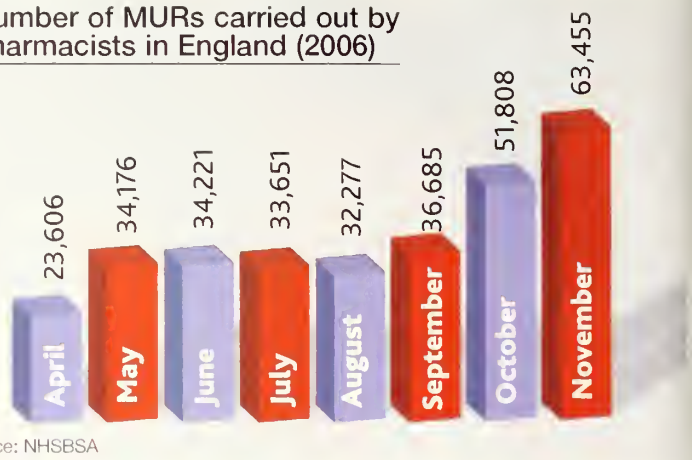
Alastair Buxton, head of NHS Services at PSNC, said the month on month growth was very pleasing.

Figures revealed a large number of MURs carried out by the multiples, including 200,000 by Lloydspharmacy and 3,500 by Rowlands. However, Mike Holden, chief officer at Hampshire & Isle of Wight LPC, said MUR success was down to the individual. "I do not think this is about multiples and independents, but more about individual pharmacists' mindset and skill mix. Success cannot just be measured in numbers, but should also reflect quality and patient benefit plus how this service is embedded in patient care pathways."

In Hampshire & Isle of Wight, one multiple has carried out 400 MURs, with 11 in the 200 to 400 range. Two independents have exceeded 200 and eight others have carried out more than 100, Mr Holden said.

"Anecdotal feedback indicates a significantly higher uptake since the start of 2007," he said.

An NPA spokesman added: "Among community pharmacies there isn't a diktat from head office to carry out MURs, but they are on the ball."



Treatment options for type 2 diabetes: see p17

Lloydspharmacy makes it 200,000 MURs

Retailing Multiple attributes achievement to improved service

Lloydspharmacy has conducted 200,000 medicines use reviews, the retailer has revealed. In addition, 23 of the chain's pharmacists have carried out 400 MURs, Lloydspharmacy said.

Andy Murdock, pharmacy director at Lloydspharmacy, said the chain made improvements to the service as a result of last year's audit of patients, pharmacy staff and GPs.

"The results of the subsequent changes speak for themselves – our pharmacists carried out the second 100,000 MURs in just seven months," he said.

Mr Murdock would now like to see more GPs direct their patients to community pharmacists or ask their local pharmacist to offer MURs at the GP practice.

Chris Blair, pharmacist at Lloydspharmacy in Mottingham, south east London, completed 400 MURs at the end of last month after starting off in April 2006.

"I can easily do five to six per day," she said. "They generally take 10 to 15 minutes each. I do the paperwork as I go along. All credit to my counter staff who helped recruit patients. It took time to raise their confidence, but once they got going it was difficult to stop them."

Ms Blair said she would advise any pharmacist wishing to carry out MURs to engage the support of their staff. **JE**

An audit of patients, pharmacists and GPs helped Lloyds notch up 100,000 MURs in seven months

in the spotlight

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News in brief

Parkinson's warning

Orion UK has added a special warning with regard to pathological gambling, increased libido and hypersexuality to the SPC of the Stalevo levodopa, carbidopa and entacapone combination treatment for Parkinson's disease. This follows a European Pharmacovigilance Working Party review that revealed that patients treated with levodopa combined with dopamine agonists may exhibit these traits.

Pre-reg promotion

Numark is visiting career fairs and open days at pharmacy schools to promote independent community pharmacy.

According to Mimi Lau, director of professional services at Numark, increased government funding and the need for pharmacists to plan their future workforce has led to more pre-reg placements in independent pharmacies.

For a schedule of visits contact Sue Watkins on 01827 841200.

Extra services in NI

A large proportion of Numark pharmacists in Northern Ireland are offering innovative services, a Numark survey has found.

Around 96 per cent are involved in the minor ailments scheme, 85 per cent offer repeat dispensing and 70 per cent smoking cessation, according to the survey of 150 pharmacies. Women's and men's health services are offered by a third of respondees, Numark said.

Nucare supports MURs

Nucare Professional Services has teamed up with Sutton, Merton & Wandsworth LPC to produce a booklet called MUR Step by Step to encourage and help independent pharmacists to increase their uptake of MURs.

JPA visits NPA

Independent prescribing, supply issues and how to deal with the pharmaceutical industry were topics discussed with the NPA when a delegation from the Japan Pharmaceutical Association (JPA) visited the UK. They also wanted to know about changes in UK community pharmacy and how the NPA is supporting members in the implementation of new services.

Cross-party MPs to screen electronic records

IT Inquiry to cover who can view confidential data

Ailsa Colquhoun

The Health Select Committee is to conduct an inquiry into electronic patient care records.

The HSC inquiry will look at:

- What patient information will be held on the local and national electronic record systems and whether patients may prevent their personal data being placed on systems.
- Who will have access to locally and nationally held information and under what circumstances.
- Whether patient confidentiality can be adequately protected.
- How data held on the new systems can and should be used for purposes other than the delivery of care, eg clinical research.
- Current progress on the development of the NHS care records service and the national data spine and why delivery of the new systems is up to two years behind schedule.

Geoff Mackay, a consultant at independent IT and business consultants Stirling Consultants, added: "In relative terms the NPfIT is not a poorly performing project and I suspect the HSC's conclusions will be tame and nothing that we have not heard before. But without a doubt, the NPfIT will benefit patient care. It's easy to throw stones but what we really need is for somebody to get on and deliver it."

The NPA is formatting its response ahead of the evidence sessions, which are expected to be after the Easter recess. A spokesman for the NPA said:

"What we need now is to have a debate about what the profession will gain from access, what information pharmacists need to make effective decisions, and what the benefits to patient safety are."

Access to patient care records will be examined by the MP inquiry

Is there resistance to pharmacy access to records? See p28

The man who led the Boots team (inset) that discovered ibuprofen has been honoured with the opening of a new research facility in Nottingham. The Stewart Adams Building is on the site on Pennyfoot Street where Dr Adams (above) carried out his pharmaceutical research during the 1960s. It is the second phase of BioCity Nottingham, the bioscience incubation centre, and will focus on medicinal chemistry and pharmaceuticals. Now 83, Dr Adams told C+D that he was very pleased that the building had taken his name because it acknowledged all the good science that came from the scientists who worked in research at Boots

Call for wider training

RPSGB Report calls for altered training focus

University courses should better reflect a trend for pharmacists to combine work in the community with industry, higher education and primary care, according to an industry report.

Schools of pharmacy must convey the challenges offered by each sector to help students make career choices, concluded the Royal Pharmaceutical Society report.

Undergraduate education could include core training on the roles of pharmacists in different pharmacy sectors, concluded the Competencies of the Future Pharmacy Workforce report.

The report notes that while only a small number of pharmacists work in industry, education and primary care sectors, community pharmacists may be looking for increased work flexibility, or to use their current experience as a grounding for work in research or teaching. **AC**

LABAs in line for MHRA review

linical Review team to assess use of formoterol and salmeterol in asthma and COPD

avin Atkin

he MHRA is to review the fety and appropriate use of the ng-acting beta$_2$ agonists rmoterol and salmeterol in thma and chronic obstructive lmonary disorder.

The review follows two influential pers published last year. One owed patients taking LABAs had poorer outcomes if they were not also taking inhaled steroids, particularly in African-Americans. The other showed asthma patients taking salmeterol or formoterol suffered more exacerbations requiring admission.

The review team will focus on how inhaled corticosteroids influence LABAs' effects, possible differences between the actions of salmeterol and formoterol, and assess the significance of genetic background.

Following the new evidence, the recently renamed Commission on Human Medicines has already issued advice on using LABAs in chronic asthma. It advises LABAs should:

- be added only if regular use of standard-dose inhaled corticosteroids has failed to control asthma symptoms adequately
- not be initiated in patients with rapidly deteriorating asthma
- be introduced at low dose and the effect properly monitored before considering a dose increase
- be discontinued in the absence of benefit, and
- be reviewed as clinically appropriate.

More information is available at http://tinyurl.com/yo5pls

News in brief

Multi-dose merger

MTS Medication Technologies, the upplier of multi-dose packaging roducts, has entered the German narket with the acquisition of CDH Consilio for around £377,000. The firm s a distributor of consumable nedication punch cards. MTS plans to onvert CDH Consilio customers to its wn punch cards, introduce its utomation systems in Germany and ncrease its European presence.

Award entries

Nominations for the GlaxoSmithKline nternational Achievement Award should be sent to Dr Sanober Shaikh, science advisor at the RPSGB by March 31. Applications are invited from researchers who have advanced scientific knowledge within the pharmaceutical sciences. The winner will receive a cheque for £1,000 and be invited to give a lecture at the British Pharmaceutical Conference in September. Go to www.bpc2007.org

Chlamydia guidelines

New guidelines on the treatment of genital *chlamydia trachomatis* have been issued by the British Association of Sexual Health and HIV.

Recommended regimens include either doxocyline for seven days or azithromycin in a single dose, or erythromycin for 10 to 14 days or ofloxacin for seven days. Go to http://tinyurl.com/2acy87 for details.

Alzheimer's event

Alzheimer's will be the topic of the Royal Pharmaceutical Society's Bradford & District meeting on March 5 at the Ramada Jarvis Bankfield Hotel, Bingley. Details from branch secretary Kevin Frost on 07932 723067.

Your views

Pharmacists with special interests – a special breed

Steve Dunn urges pharmacists not to ignore the chance to acquire greater status

The publication of a national framework for the guidance of pharmacists with a special interest (PhwSIs) is being hailed by the DH as a significant step forward for the pharmacy profession in delivering front line clinical services within the community.

It will be a significant advance for the Department too, if it attracts the desired response. It will do much to ensure that patients and the NHS gain the maximum from pharmacists' clinical training and knowledge and, above all, their expert knowledge of medicines.

It is too early to gauge how contractors will react and how many of them will be keen to demonstrate they have the ability and qualifications to deliver in such areas as drugs misuse, diabetes, asthma and anticoagulant monitoring.

In some parts of the country the far-sighted are already doing so, tackling long-standing health inequalities by giving patients easier access to specialist services, in familiar settings much closer to home.

But how adventurous will the profession as a whole be?

Crucial to the exercise is establishing with PCTs whether they in fact intend to fund enhanced services in the first place.

It has become evident to them during the development of practice-based commissioning that PhwSIs have the necessary expertise to support provision that is not only clinically effective but convenient for patients and gives good value. But it will have to be paid from existing budgets that many PCTs argue are already inadequate for what they are being expected to achieve.

So it is safe to assume that PCTs will not actively seek pharmacists with specific services to offer, and that pharmacists will need to approach PCTs. That is why showing how to develop approaches and a dialogue with these bodies is very much a part of AAH's pharmacy support package.

Once they have sold the merits of what they have to offer they must complete an accreditation process to verify they have the ability to furnish the higher level of clinical skill required and to manage the higher degree of risk.

That will naturally include having to show they have the appropriate training and certification to supply a service beyond the scope of their core professional role, which will often involve spending time away from business to attend courses.

They must also demonstrate commitment to ongoing training, updates and education through appraisals and their CPD record, as well as providing satisfaction on a number of other demands.

As might be expected these are fairly comprehensive and include:

- Showing clear understanding of the role they are being asked to fulfil and of the context in which they will be delivering the services.
- Defining appropriate peer review and mentoring arrangements.
- Describing how the proposed role fits within their existing portfolio.
- Demonstrating a systematic approach to clinical risk management.
- Having in place suitable indemnity arrangements.

Furthermore, though it will be seen as secondary to service provision, they will be expected to play a leadership role within their local health economy, contributing to strategic planning and participating actively in clinical networks.

So – is it all worth it? Very much so, in my view.

Special interest status will allow pharmacists to expand their skills, knowledge and experience to the benefit of patients and community healthcare while at the same time expanding their practice and creating new income streams.

It will also add considerably to their image and their standing. Like GPs they will deliver clinical services directly to patients and without supervision, undertake advanced interventions and establish a personal interaction and clinical relationship with those in their care.

Becoming a pharmacist with a special interest will give pharmacists the opportunity to show what they can do – to show off their skills and knowledge more fully than they have ever been able to do before. They should do their utmost to seize it.

Steve Dunn is group managing director of AAH Pharmaceuticals

PDA comment: A chance for change

Has the time come for closer relationships between pharmacy organisations, asks Mark Koziol

I cannot remember a time when the question over the future roles of the various bodies in pharmacy has arisen in such a dramatic way.

The RPSGB has launched a review to examine the principles around separating its functions. If it chooses to become a professional body, it will need to look after the interests of all its members.

Some members of RPSGB staff will have little experience of working as purely a membership body and will need support through the process of change. Some may leave and already the chief executive has announced her retirement.

With Boots joining the NPA as an associate member and with the emergence of a strong Company Chemists' Association, independents may have felt that their voice has become diluted. Elsewhere, we have seen the launch of the Independent Pharmacists Federation. More recently, the NPA has also lost its leader.

With the emergence of the Pharmacists' Defence Association, it is also clear that employee and locum pharmacists have felt the need to have their interests looked after.

I have heard it said that pharmacy has suffered because there are too many organisations speaking on behalf of the profession and this causes confusion. But surely, we must consider that we are now a profession of largely employed and self-employed individuals, working in two main branches: hospital and community.

Some pharmacies are owned by pharmacists, some by non-pharmacists and others are owned by large Plcs. Increasingly, individual pharmacists are also working in new roles and in new settings. There will be many, varied and often conflicting needs of all these constituencies, and one organisation, trying to look after all these disparate needs simultaneously, would surely find itself paralysed into inactivity.

But equally, I do not believe that the answer lies in maintaining the status quo. It is my belief that, with all of the changes currently on the horizon, we now have a historic opportunity to begin to make some sense of the bigger picture.

Perhaps the time has arrived for all the (often competing) pharmacy organisations to meet to explore any common agendas that could benefit from some collaborative working. Additionally, if they could reach an agreement on who does what, then this may further untangle the lines of communication. It would also reduce a considerable amount of duplication of effort, not to mention arguments over who provides what service to whom. Imagine how much progress could be made if all of the pharmacy organisations could develop their own unique roles without the threat of another organisation trying to usurp their role.

Most importantly of all, such an initiative could go a long way in helping our professional organisations configure themselves in a way that best serves the membership into the long-term future.

Mark Koziol is chairman of The Pharmacists' Defence Association

For diabetes

Gentle testing is here

Good news for your customers who don't like getting sore fingers

FreeStyle Freedom™ uses the world's smallest blood drop, from a pinprick so shallow it can hardly be felt. Clinical tests have shown that 100% of people found testing with FreeStyle™ either virtually painfree or painless. Designed to be easy to read and hold, FreeStyle Freedom™ is also ideal for customers whose eyesight isn't as good as it used to be.

FreeStyle™ back on TV

Good news when they need help choosing a meter

Abbott has a range of blood glucose meters suitable for different people and their lifestyles. To help you select the best meter for them, we've produced a patient/meter selector wheel. Call now for your **FREE** wheel and for details of supporting point of sale material.

FREE selector wheel

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Blood Glucose Monitoring System

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Abbott
A Promise for Life

Comment from the editor

Radical change – but what will the fallout be?

So, the RPSGB is to lose its regulatory role to a General Pharmaceutical Council (GPC) according to this week's 'historic' White Paper from the Department of Health.

As well as regulation and the inspection of pharmacy premises, the GPC will (as the future regulatory body) ensure standards for education are maintained.

Furthermore, the White Paper proposes that for those, including self-employed contractors, performing services commissioned by NHS organisations (we presume this is the category into which pharmacists fall) revalidation will be carried out under the supervision of the commissioning organisation and the regulatory body.

So the question is where does this leave the Royal Pharmaceutical Society and the Pharmaceutical Society of Northern Ireland? What role will they have in the future, and why, when there has been no question of them failing in their duty to protect the public or to uphold standards, do they appear to have been left out in the cold? Despite its bold announcements, the White Paper leaves many questions unanswered.

It's true, the White Paper talks of a Royal College to support excellence, professionalism and innovation in the science and practice of pharmacy, and one that will be expected to contribute its expertise to the new GPC, but isn't this in essence what the RPSGB does? So will the RPSGB be the new Royal College that sets the education standards or will that too be a new entity?

Further issues are where will the GPC be located and how will it be funded? Will pharmacists have to pay for its setup as well as ongoing registration? Or does the DH expect the new Council will be housed in Lambeth at members' expense?

It seems the obvious role for the Pharmaceutical Societies will be leadership. But with organisations such as the NPA and PSNC already staking their claim as providers of expertise in professional and contractual matters, it will be difficult for another body – without mandatory membership – to gain a firm footing.

There are no doubts that the DH's latest plans will radically change the way the profession is regulated. But the impact of the fallout on the rest of the sector's support structure is as yet unclear. Not for a long time has the profession so looked forward to the RPSGB's next Council meeting.

Does the DH expect the GPC to be housed at members' expense?

Locum at large

Worthy of his hire?

If only pharmacist salaries could attract as much attention as those of GPs, says our locum columnist

Press reports that the average GP's earnings have rocketed (with figures of £120,000 per annum and more being cited) must have made many pharmacists choke on their breakfasts. Was this a classic case of bungling by the civil servants negotiating doctors' remuneration or a clever piece of negotiation by the GPs' representatives? Probably a bit of both, but for many it appears that having withdrawn from weekend work, and knowing the difficulty that patients can experience in even making an appointment to see their doctor, this must be the classic case of a group getting considerably more for doing considerably less.

With nurses also having obtained a 67 per cent rise in their salaries over the past three years and the average dentist heading up to £80,000 a year and more, one must inevitably ask oneself: "Where did pharmacy go so wrong and why are pharmacists so rapidly falling behind other healthcare professionals in their remuneration?"

I seem to remember reading somewhere that between 1995 and 2005, pharmacists' remuneration, allowing for inflation, increased by a miserly 3 per cent. That is 3 per cent over 10 years, not 3 per cent per year. Whatever the rate, what other calling would put up with such a situation or allow it to occur in the first place?

Looking at the remuneration being offered in advertisements for pharmacists, salaries of just over £30,000 a year are still being offered and anything over £40,000 a year is thought of as being well paid. With meaningful annual bonuses being phased out for many pharmacists and counter staff alike, in real terms salaries in pharmacy are hardly moving at all, barely keeping pace with inflation. Most pharmacy counter and dispensing staff would, I suspect, be better off working as domestic cleaners earning £10 per hour or more.

Some dispensing and counter staff have not had a salary increase or annual bonus for more than three years. What sort of way is that to retain the loyalty of staff and reward their hard work? Periodically rejigging salary scales and declaring that some staff are now overpaid and will have to wait for the scale to catch up with them is a practice unworthy of any professional manager, yet it takes place.

To pay a locum £20 or less per hour is an insult, but few employers pay much more. And those pharmacists have to fund holidays, pensions, periods off work, as well as mortgages and other household and family expenses.

So are we our own worst enemies or are we helpless in the face of the combined ranks of employers and a Treasury dedicated to paying as little as possible for pharmaceutical services? Are we condemned forever to be the Cinderellas of the medical services, with absolutely no evidence that delivering more and more services to the NHS is going to make a scrap of difference to pharmacists' individual salaries?

How many doctors would put in the hours that pharmacists do for a third of their present wage, or dentists for half of theirs?

Nowhere can I see any financial inducement in any aspect of the present contract that indicates that extra effort leads to extra rewards for the individual pharmacist, such as the doctors have achieved.

Perhaps this is something that should be considered because the rewards being paid to contractors are very definitely not being passed on to their employees, the very people who are generating the increasing income from dispensing, MURs and other services.

Xrayser

Boots stops us going soft

Where would we be without Boots? Apart from the obvious wet socks I think we would be more complacent both professionally and in our business practice. Despite its faults, Boots The Chemists is responsible for more than its fair share of innovation within pharmacy.

We have Boots to thank for groundbreaking pilots on chlamydia testing and supplying Xenical via PGD, to mention but two areas where it has more or less single-handedly pushed the professional boundaries in the right direction. And now we have Viagra under a PGD (C+D, February 17, p4).

Supplying Viagra under a PGD is a brave move, certainly innovative and definitely risky. I'm sure a lot of other pharmacists would like to get in on this act but feel unable because they lack the financial muscle or practical knowhow. I'm not one of them.

I haven't yet had the opportunity to get involved in any PGDs but would very much like to be part of one to supply EHC to under 16s. And supplying antibiotics for chlamydia also appeals. These both seem sensible extensions to my current role that would meet a local health need.

I don't see a local health need anywhere in this country for better access to Viagra. You can buy it on the internet, for heaven's sake. And I don't believe that 21st century men are likely to be any less embarrassed asking their pharmacist for Viagra than they would be asking their GP.

If impotence is as big a problem as Stirling Moss claims, I'm surprised I don't see more Viagra prescriptions. This is hardly down to lack of awareness – these must be the most high profile tablets on the planet. Pharmacy supply is hardly the answer, certainly not when consultations are reported to take an hour and you still need to see a doctor for your second supply.

Hour-long consultations on erectile dysfunction? No thank you. That is a role for people with a specialist interest, and somebody somewhere has to judge whether the end result is worth an hour of pharmacists' time. Boots is asking consumers whether they think it's worthwhile and I look forward to hearing what they decide.

Whatever happens, Boots is taking the risk and the rest of the profession can only gain from their experience. Even if Viagra on PGD never takes off, this scheme will serve to open a few more minds to the untapped potential of the community pharmacist.

Easy rider?

It's been all uphill this week. All my staff were either off sick or generally miserable with the flu, nobody wanted to have an MUR, everybody wanted to ask my advice, the computer crashed and the local surgery sent nearly a whole week's worth of prescriptions on one day.

It's just like that sometimes. I'm hoping for an easier ride next week: my computer's fixed, staff are on the mend and I've got a few MURs booked in. That just leaves difficult patients, the end of the month paperwork and a potentially awkward meeting with a local GP practice.

On the plus side: well at least the snow's melted and my patients feel safe enough to step outside. But just when they thought it was safe to venture out, the council is threatening to dig up the pavement in front of the shop.

I never expect an easy ride but the occasional tail wind would be nice.

Xrayser C+D 24 tablets inside

Black Bag

Can I be Frank?

When Viagra was first launched the then secretary of state for health, Frank Dobson, limited NHS prescriptions through Schedule 11 because men, he claimed, would abuse it for "recreational sex".

Tricky area this because most sex is recreational, otherwise there would be baby-buggy snarl ups on the high street that make the M25 look like a country lane. Perhaps he was thinking about the things posh people get their coal in.

So was stopping men getting their hands on the little blue diamond a good idea when it came to saving the NHS? Not quite. Erectile dysfunction is the best sign of underlying diabetes, hypertension and cardiovascular disease. Getting men with ED to see a health professional early would save the poor old NHS countless millions, not to mention winning a few votes.

February 14 was an obvious choice to bring Viagra closer to men via the pharmacist but doctors queued up to criticise the shift away from general practice. Now check your emails; count the number of Viagra adverts with not

Most sex is recreational otherwise there would be baby-buggy snarl ups on the high street to make the M25 look like a country lane

the slightest possibility of diagnosing the underlying causes of ED and only 10 per cent of men with ED ever presenting to a doctor. Pharmacists are ideally placed and trained, especially with their ever expanding on-site tests for diabetes, hypertension etc.

Frankly Frank, you got it wrong and as Schedule 11 is still in place, men continue to live with your mistake. Allowing pharmacists to improve the pick-up rate and bring a smile to both men and women can't be all bad.

That soft hissing noise you could hear when you sat in the Department of Health was St Valentine rotating in his urn.

Dr Ian Banks is a GP practising in Northern Ireland

Pharmacy Champions

Pharmacists leading the way

Nominate your Pharmacy Champion:
Telephone 01732 377688
or email chemdrug@cmpmedica.com

Name
Jonathan Lloyd

Pharmacy
The Health Centre Pharmacy, Carrickfergus, Co Antrim

What has he done?
He is constantly investing in new services, raising standards and promoting pharmacy

What have you set up?
The pharmacy is based in the only medical practice in Carrickfergus and until recently the dispensing of prescriptions provided nearly 100 per cent of our income.

We work closely with all health centre staff in an atmosphere of mutual communication. We offer a number of services including repeat prescriptions and medicines management consultations while patients are attending chronic illness clinics at their GP surgery. We supply free advice and NRT with our smoking cessation service. To date we have counselled more than 450 patients and the quit rate at four weeks is 54 per cent.

We also took part in a medicine taking assessment tool pilot project, which has led to the provision and growth of an MDS service.

I've completed the supplementary prescribing course at Queen's, Belfast, and the IP conversion. I've registered with the PSNI and plan to run a chronic pain clinic within one of the GP practices to complement the medicines management service.

In addition, we offer free blood glucose meters and can print the glucose results for the past month for the patient to take to their GP. We are involved in the palliative care scheme within Northern Ireland's northern board.

We advertise our services by putting leaflets in waiting prescription baskets suggesting a service that may help with specific ailments. We also promote them in the health centre and place weekly ads in the local newspaper for the smoking cessation service.

We have an online prescription ordering service,

where users create a unique personal profile that is updated each time they log on to our website. Repeat prescription items can be simply and securely ordered via a system that maintains confidentiality at all times. More than 400 patients have registered to use the service.

What has been the high and low point of setting up the services?
Seeing your ideas work for the benefit of the patients, GPs and the pharmacy. The low point has been the struggle to remove or manage the bureaucracy within the NHS. The fact that the government, drug companies and health boards constantly move the goalposts doesn't help.

How much did you need to invest ?
I'm constantly investing in new services, however most of this is in my own time. Although I get a lot of job satisfaction, what I do is rarely recognised financially. It's a problem that all pharmacists have to face. The reward may not be evident initially, but returning customers soon provide the motivation to carry on.

How have the patients, GPs and other healthcare professionals reacted?
It takes time for GPs to take up the new services we offer, but once they can see the benefit they soon start using the pharmacy and we reap the benefit. It's all about good communication.

Do you have any advice for others wishing to set up new services?
Although most new services do not sit comfortably within a busy pharmacy, pharmacists must start to adapt and work out how to manage all the jobs that have to be done in the working day. This takes time and will not happen overnight.

Why do you think you've been successful?
I won't think that I've been successful until the customers routinely use pharmacy to its full potential. This can only be achieved over time. Pharmacy must constantly strive to raise standards and promote the profession with one clear, loud voice.

C+D Clinical

Drugs used in type 2 diabetes

Our second article on type 2 diabetes looks at current thinking on managing high blood glucose levels

Key points

- Type 2 diabetes is a progressive disease that requires multifactorial treatment.
- Correcting high blood glucose is important but it is essential to treat other risk factors, particularly hypertension and high cholesterol.
- Treatment goals are to relieve acute symptoms and prevent long-term complications while avoiding hypoglycaemia.
- A step-up approach is recommended, starting with lifestyle interventions and progressing from monotherapy to combination therapies and then insulin.

Claire Jones

It is important to remember that type 2 diabetes is a multifactorial disease and so it is essential to address all risk factors, particularly hypertension and high cholesterol, as well as high blood glucose levels. Studies suggest that tight control of hypertension, for example, might be just as important as controlling hyperglycaemia.

Diagnosis and general management of people with type 2 diabetes were covered in the first of these two articles (C+D, February 17, p17 to 19).

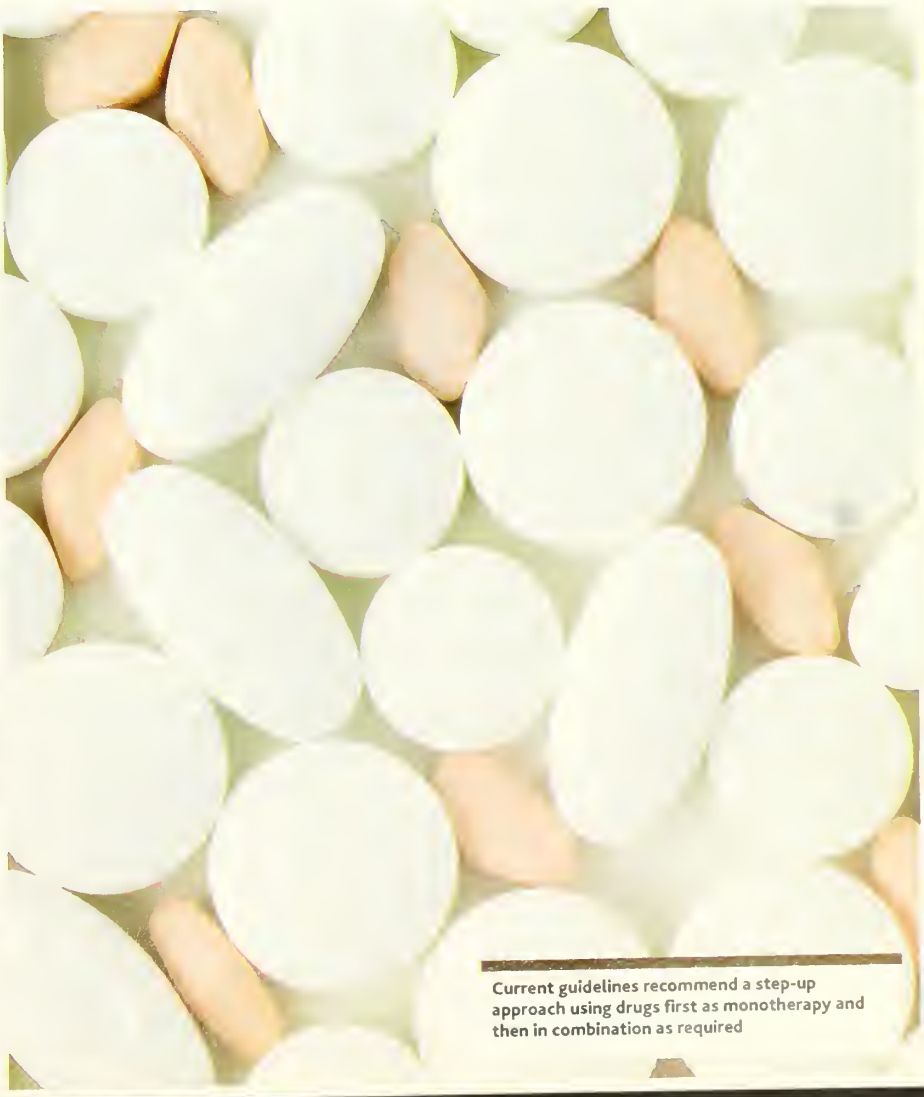
The various tiers in the new pharmacy contract enable community pharmacists to support people with type 2 diabetes in many ways, from encouraging early diagnosis to helping them with medication and persuading them to have regular reviews.

Reflect

How up to date is your knowledge of hypoglycaemic drugs? For example, what are the main side effects of the sulphonylureas? When is metformin the treatment of choice? Why is self-monitoring of blood glucose controversial?

Plan

This article will update your knowledge of the drugs used in controlling high blood glucose in type 2 diabetes, including insulins.



Current guidelines recommend a step-up approach using drugs first as monotherapy and then in combination as required

The College of Pharmacy Practice

This course (module 1397), in association with multiple choice questions being published in C+D March 3, provides one hour's continuing education

CPD

This article can help in the following CPD competencies: C1a, C1c, C1d, C3e. See www.tinyurl.com/194zu

General guidance

Diabetes management is described in various national guidelines, mostly in the NSF for Diabetes and in Nice guidance. In 2006, the National Diabetes Support Team published a booklet for healthcare professionals summarising all Nice publications that involve diabetes care – this is an excellent starting point.[1] NHS Clinical Knowledge Summaries (formally known as Prodigy guidelines) are another excellent source of review.[2]

A step-up approach

Current treatment guidelines recommend a step-up approach starting with diet and exercise, adding drugs, first as monotherapy, then in combination, and finally insulin if blood glucose targets are not achieved. Because of the progressive nature of the disease, most patients with type 2 diabetes ultimately require insulin.

Diet and lifestyle changes alone can be tried for the first few months (unless a patient presents with severe symptoms and/or very high blood glucose levels). Lifestyle interventions were covered last week.

If targets are not achieved then a trial of one drug is recommended:

- Obese patient with normal renal function: metformin.
- Obese patient with impaired renal function: sulphonylurea.
- Non-obese patient with normal renal function: sulphonylurea or metformin.
- Non-obese patient with impaired renal function: sulphonylurea.

If targets are still not achieved then combination therapy should be tried:

- First line combination therapy: sulphonylurea and metformin.
- Second line combination therapies if first line not working, not tolerated or contraindicated:

1. metformin and glitazone
2. sulphonylurea and acarbose
3. sulphonylurea and glitazone

If targets are not achieved, then patients will be referred to a diabetic clinic for insulin therapy (note: the licensed glitazones are contraindicated in combination therapy with insulin).

Drug interventions

The various UK Prospective Diabetes Study (UKPDS) trials published in 1998 provide the mainstay of evidence for the aggressive and multifactorial treatment of type 2 diabetes that we see today. These trials compared a fasting blood sugar control of less than 15mmol/l (ie conventional control) with less than 6mmol/l (ie intensive control), and a blood pressure control of 150/85mmHg with 180/105mmHg.

The trials showed that:

- Type 2 diabetes is a progressive disease: after three years, half the patients on monotherapy could attain the goal of HbA1c less than 7 per cent. By nine years this declined to 25 per cent. Within three years of onset of type 2 diabetes, half the patients needed multiple therapy in order to achieve glycaemic control.
- Tight blood glucose control with either sulphonylureas or insulin reduced microvascular complications (particularly retinal damage) but not macrovascular end points or death.
- Tight blood glucose control with metformin in obese patients reduced all trial end points of macrovascular and microvascular complications, and death.
- Tight blood pressure control in all patients reduced all trial end points of macrovascular and microvascular complications, and death, suggesting that tight control of blood pressure may be even more important than strict blood glucose control. After nine years, a third of patients required a combination of three drugs to maintain the target blood pressure.

It is because of these studies that we see the first line use of metformin and sulphonylureas to control blood glucose. Since UKPDS, other classes of drug have emerged but not yet with the convincing evidence-base to show that they also reduce long-term complications. In particular, recent trials have involved the glitazones (see NeLM In-Focus Reviews[3] or MeReC Extra[4] for good independent summaries).

Main features of drugs used to lower blood glucose

Metformin

- Does not cause significant hypoglycaemia when used alone.
- Gastrointestinal (GI) side effects are initially common (in five to 30 per cent of patients). Start dose slowly over two to six weeks to limit these side effects.
- Hepatic and renal function should be regularly monitored.
- Lactic acidosis is a rare but serious side effect that can result from metformin accumulation. Reported cases in patients on metformin have occurred primarily in those with significant renal failure.

Sulphonylureas

- No evidence of clinically important differences in efficacy between agents within the group.
- Main side effect is hypoglycaemia. Those with a long duration of action (eg glibenclamide) are associated with a greater risk of hypoglycaemia, and should be avoided in the elderly.
- Weight gain, typically from two to 5kg, is commonly associated with the sulphonylureas.

Glitazones

- Current Nice guidance does not recommend a combination of metformin or a sulphonyluria with a glitazone, unless there are compelling reasons why the first line combination of metformin and a sulphonylurea cannot be used (eg poorly tolerated or contraindicated). At the time of writing both rosiglitazone and pioglitazone are also licensed as:
  - monotherapy for those in whom metformin is inappropriate because of contraindications or intolerance, and
  - as part of triple therapy with metformin and a sulphonylurea (they are both contraindicated for use in combination with insulin).
- Can cause fluid retention, which may exacerbate or precipitate heart failure.
- Are associated with weight gain (similar to that seen with the sulphonylureas), probably because of fluid retention.
- There have been rare reports of hepatocellular dysfunction. Nice recommends that liver function tests should be performed before initiation of therapy then every two months for the first 12 months of treatment, and periodically thereafter.

Acarbose

- Decreases absorption of glucose from the GI tract.
- Should be initiated at a low dose and increased gradually to reduce the likelihood of GI side effects.
- Patients also using sulphonylureas and/or insulin should be counselled that they will need to use glucose and not ordinary sugar (sucrose) to treat a hypoglycaemic attack.

Meglitinides

- These have a rapid onset and short lasting effect, with a mode of action similar to sulphonylureas (therefore can also cause hypoglycaemia).
- At the time of writing, repaglinide and nateglinide are licensed for use as combination therapy with metformin, and repaglinide is also licensed for use as monotherapy.
- Nice recommends that these drugs may have a role in attaining tight glucose control in patients with non-routine daily patterns, as they are taken just before a meal.

Insulins

- Because of the progressive nature of the disease, most patients with type 2 diabetes ultimately require insulin therapy.
- These patients will need additional support

from their community pharmacist, for example in understanding the importance of self-monitoring blood glucose levels (to check for hypoglycaemia and blood glucose changes during dietary modifications, exercise and concomitant illness), in the correct use of blood glucose meters and pen injectors, in managing hypoglycaemia, and knowing how to dispose of sharps, etc. NPA information leaflets on these issues are helpful for pharmacists.

- Two areas of development are in the growing use of the insulin analogues, and in the recent introduction of inhaled insulin.
- Nice guidance is available on the long-acting insulin analogue insulin glargine. This analogue is not recommended for routine use and, in type 2 diabetes, it should be considered only in people who 1) require assistance from a carer or healthcare professional to administer their insulin injections; 2) whose lifestyle is significantly restricted by recurrent symptomatic hypoglycaemic episodes; or 3) who would otherwise need twice-daily basal insulin injections in combination with oral antidiabetic drugs.
- In December 2006, Nice guidance on inhaled insulin recommended that it should only be used where, despite all conventional treatments, a patient's blood sugar is not being controlled, and the patient is not able to start using or increasing insulin injections because of a medically confirmed needle phobia or because of severe and persistent problems with injection sites. In January 2007, the Drugs and Therapeutics Bulletin reviewed inhaled insulin and concluded that "we can see very few situations where the potential benefit [ie in patients with proven needle phobia] outweighs the safety concerns and considerable expense associated with the treatment".

Self-monitoring

Self-monitoring in type 2 diabetes remains controversial. Current Nice guidance states:

- Self-monitoring may have a role to play as part of an integrated self-care package.
- There is no evidence that blood glucose monitoring is more effective than urine testing as part of an integrated self-care package in improving blood glucose control.
- There is no evidence that self-monitoring of blood or urine glucose improves blood glucose control.

The UKPDS trials showed that HbA1c measurement contributed to improved long-term blood glucose control and morbidity (in terms of a reduced risk of microvascular end points). So measurement of HbA1c is likely to provide more helpful information about glycaemic control than day-to-day self-monitoring. There does seem to be agreement that self-monitoring is helpful for type 2 diabetes patients who are moving over to insulin therapy, as insulin doses can only be adjusted appropriately on the basis of self-monitored blood glucose levels at different times of the day.

If people with type 2 diabetes not using insulin are encouraged to self-monitor then there are likely to be local consensus guidelines on the method to be used and how often patients should perform these tests.

Patients can find blood monitoring painful, inconvenient and difficult and so it is essential that they receive the appropriate training. Meter errors or non-compliance often arise when patients are not given enough information about monitoring, lack motivation, or find testing complicated and confusing.

A survey of 93 patients who visited a UK pharmacy in 2001 for advice about blood glucose meters revealed numerous problems. About half had difficulty sampling blood (eg they could not produce enough blood to cover the test strip, or forgot to wash their hands before testing to remove residual sugar from the fingers). More than a third did not keep the measuring chamber of their meter clean, and one patient had bought three meters but could not use any of them.

Claire Jones is now practising as a community pharmacist and carrying out consultancy work after four years as assistant head of NHS service development at the National Pharmacy Association. She previously worked as a pharmaceutical adviser and National Prescribing Centre trainer.

Continuing Professional Development CPD

Act

- For an excellent review of treatment options go to http://tinyurl.com/34yxp7 (this requires registration or Athens membership).
- Another useful review of the mechanism of drugs used for type 2 diabetes is at http://www.patient.co.uk/showdoc/40001626
- Lifestyle changes are regarded as the first line treatment. Review these changes(C+D, February 17, p17 to 19, and find others on the web).
- Record the prescribed drugs issued to the next 50 patients taking oral hypoglycaemic agents. Analyse the hypoglycaemic agent(s) and drugs prescribed to control allied conditions (hypertension, eye problems, etc). Do these results agree with the therapies noted in the article and elsewhere? Do the majority of such patients have hypertension? Are there any other common problems you can identify?
- Use your PMRs to identify more patients with type 2 diabetes. Look at their drug history. Can you note any progression of the condition reflected by drug changes? Can you identify any worthwhile intervention you could make (advice on weight and diet, lifestyle changes, exercise, etc)?
- Make sure you know when patients should take their drug(s) and the potential side effects.

Evaluate

- Do you feel more confident when discussing lifestyle changes with patients just diagnosed as 'borderline' diabetics? When you give out a prescribed oral hypoglycaemic agent to a new patient, do you understand the rationale of the prescription? Do you then provide advice on all aspects of their medication and their future life?
- What more do you need to know? And where will you find such information?

Distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C+D readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the March 3 issue, which will cover this week's CPP-accredited module, together with those in the February 3 and 17 issues.

These will cover:
- Treating cystitis and PMT (1395)
- Diabetes part 1 (1396)
- Diabetes part 2 (1397)

A telephone marking service offers independent verification of results (see the monthly MCQ papers in C+D for details). If you wish to register for Pharmacy Update, please contact Pauline Sanderson on 01732 377269.

Chemist + Druggist
in association with
Genus Pharmaceuticals

C+D GENUS PHARMACEUTICALS

A Practical Approach...

It's a very busy morning at the Update Pharmacy and pre-registration pharmacist trainee Julia O'Reilly is on prescription reception. A woman hands her prescription across. It is for trazodone 50mg capsules and trazodone 150mg tablets, one of each to be taken at bedtime.

Julia sees that the patient is not exempt from NHS prescription charges and says: "That will be £13.30 please."

The woman looks surprised. "Are you sure?" she says. "Yes," replies Julia. "It's £6.65 an item, and you've got two items on here."

"But the doctor didn't say he was giving me two medicines, I thought it was just one."

"That's right, it's the same medicine but he's prescribed tablets and capsules to get the dose he wants you to take, and I'm afraid that there is an NHS charge for each."

"I don't think that's fair, it's only one medicine," the woman replies. "Can't you do something about it?"

"I'm not sure, I'll ask the pharmacist."

Hannah, the senior medicines sales assistant, has seen the queue building up behind the woman with the query and has come to help.

As Julia goes to take the script to pharmacist David Spencer, Hannah hands her another.

"Ask David about this one too, please," Hannah says. "It's for Curanail. It's an OTC line and I don't think we can supply it on the NHS."

Questions

1. Was Julia correct in asking for two charges for the trazodone?
2. If she was right, can anything be done to save the patient paying two charges, and if so what?
3. Would the situation be the same if the prescription were for amitriptyline 10mg tablets and amitriptyline 50mg tablets?
4. Can Curanail be supplied on NHS prescription, as it is not listed in the British National Formulary and a POM equivalent (Loceryl nail lacquer) is available?

Answers →

CPD

This article can help in the following CPD competencies: C5a, C6a, G1j, G8a. See www.tinyurl.com/194zu

Pharmacies are offering quality back pain advice

Pharmacists are able to offer positive, evidence-based advice for individuals presenting with low back pain, a UK study has reported.

A questionnaire filled out by 335 community pharmacists attending continuing education sessions found that in two clinical scenarios, appropriate evidence-based advice such as adequate analgesia and suggesting that movement was beneficial would be offered.

If the participant had suffered from back pain themselves they had even more confidence in their advice, researchers found.

The pharmacists were keen to help patients with low back pain and the vast majority (91 per cent) said they would like more training in dealing with complaints of back pain.

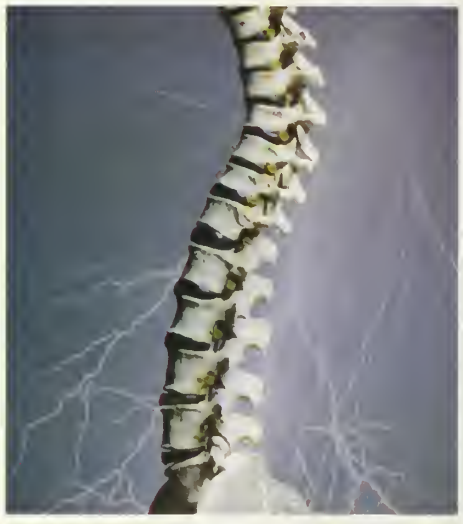
The general support for active management of the pain, for example encouraging patients to work when not pain-free, was in line with findings from a previous UK study of GPs.

However, the researchers noted the participants were cautious about recommending activity that may cause pain.

Jonathan Silcock, pharmacy lecturer in the School of Healthcare at Leeds University, said: "The survey showed that pharmacists were willing and able to provide evidence-based advice to people with low back pain.

"Training to improve the confidence and ability of pharmacists to provide advice about back pain may be a useful model for improving other aspects of self-care, especially for conditions involving some chronic pain."

He added that it would also support government policy to make self-care more widely available via pharmacies.



For more information:
BMC Musculoskeletal Disorders, early online January 31, 2007

Inherited clot risk in Pill users

Dutch researchers have highlighted the risks associated with oral contraceptive use in women who have hereditary clotting problems.

In a study of 91 families, women with hereditary deficiencies of protein S, protein C, or antithrombin were found to be at higher risk of venous thromboembolism from combined oral contraceptives than women without such deficiencies.

The annual incidence of venous thromboembolism when women were taking combined oral contraeptives was 4.62 per cent in those with hereditary deficiencies, compared with 0.48 per cent in controls.

For more information:
Archives of Internal Medicine 2007; 176: 282-89

A Practical Approach... this week's answers

1. Yes. A charge applies for each item if different formulations or presentations of the same drug are ordered on the same prescription form.
2. Yes. There are two possibilities:
a) The prescriber can be asked to write the prescription for trazadone 50mg capsules only, with a dose of four at bedtime.
b) The prescriber could just write a prescription for "trazadone 200mg at bedtime," leaving the pharmacist to supply 50mg capsules, or a combination of 50mg capsules and 150mg tablets, to fulfil the order. In the latter case the pharmacist would receive two dispensing fees but would have only one NHS charge deducted.
3. No. Different strengths of the same formulation of a drug carry only one prescription charge, although the pharmacist will receive a dispensing fee for each strength.
4. Yes. For reasons of space, the BNF has stopped including products marketed as OTCs. But Curanail is prescribable as it is not listed in Part XVIIIA (the 'black list') in the Drug Tariff.

THE BIG DROP

Amlodipine and Valsartan join forces to deliver powerful BP reductions[1,2]

NEW

EXFORGE®

amlodipine besylate/valsartan

POWER WITH CONTROL TO GET TO GOAL

For patients whose blood pressure is not adequately controlled on amlodipine or valsartan monotherapy

Prescribing information can be found overleaf.

Clinical news

Drug centre recommends glucose self-monitoring

The Regional Drug and Therapeutics Centre has issued a drug update recommending patient self-monitoring of blood glucose in type 1 and insulin-dependent type 2 diabetes patients.

Testing frequency would be up to four times daily, depending on the patient and their insulin regime.

The RDTC document says that over-monitoring has implications for costs and patient quality of life, prescribing policies and patient education. The method of glucose monitoring should be tailored to the patient's treatment, and should be reviewed regularly, it added.

Monitoring is not required in patients controlled on non-insulin therapy, however. In these patients regular HbA1c testing should continue to be used.

• The RDTC has also issued a drug update recommending that clopidogrel should only be prescribed for secondary prevention following stroke or transient ischaemic attack in patients unable to tolerate aspirin.

For more information: www.nyrdtc.nhs.uk

Sexual health not PCT priority

PCTs are failing to take sexual health seriously, a survey from several British organisations including the Terrence Higgins Trust has shown.

Money destined for sexual health has been diverted to other areas by two-thirds of PCTs, the survey found.

Prescribing restrictions are becoming more common, particularly for HIV drugs, and almost half of trusts had not assessed local sexual health needs for at least three years.

Contraception was also found to be low down the list on local health plans.

• In a webchat earlier this month, health secretary Patricia Hewitt highlighted the role of pharmacies in dealing with "lifestyle diseases". She said: "In London, we've been trialling chlamydia screening in Boots and we intend to do more, because it works so well for patients."

For more information: www.tht.org.uk

In brief

Antihistamine, intranasal steroid, nasal douche and decongestant treatments in sinusitis are not supported by the evidence, a BMJ clinical review has concluded. The authors did find evidence of improved cure rates in patients treated with antibiotics, particularly where symptoms were severe, persisted for more than five days, or were progressive. More information: bmj.com 2007; 334: 358-61

A short course of montelukast, starting when asthma symptoms first appear in children, is associated with reduced demands on health resources, according to a year-long study including 681 treated asthma episodes. Published in the American Journal of Respiratory and Critical Care Medicine, the study also saw reductions in symptoms, time off from school and parental time off work.

Correction Last week in these pages we annnounced that Atarax tablets are now supplied with a film coating. The drug name given in this news item was wrong: Atarax contains hydroxyzine hydrochloride.

NEW nicorette® nicotine ActiveStop. Additional support all the way

nicorette ActiveStop
Supporting you, body & mind

nicorette 16-hour Patch and ActiveStop

- Specifically designed to deliver only 16-hours of nicotine for effective smoking cessation[1,2]
- ActiveStop combines cognitive-behavioural techniques with the latest communication technology
- 3 out of 4 patients were satisfied or very satisfied with the ActiveStop parent programme.[3] Register at **www.nicorette.co.uk**

Nicorette Patch Product Information: Presentation: Transdermal delivery system available in 3 sizes (30, 20 and 10cm²) releasing 15mg, 10mg and 5mg of nicotine respectively over 16 hours. **Uses:** Relief of nicotine withdrawal symptoms as an aid to smoking cessation. **Dosage:** Adults (over 18 years): Patients should stop smoking and refrain from using any other nicotine products. The patch should be applied to the skin on the hip, upper arm or chest in the morning and removed at bedtime. Application should be limited to 16 hours per day. Initially one 15mg patch daily for 8 weeks. Dose should be reduced to 10mg for 2 weeks and then 5mg for a further 2 weeks. If abstinence is not achieved at 3 months, further courses may be recommended. Adolescents (12 to 18 years): As per adult, but duration of therapy should not exceed 12 weeks without consulting a healthcare professional. Under 12 years: Not recommended. **Contraindications:** Hypersensitivity. **Precautions:** Erythema may occur. If severe or persistent, discontinue treatment. Unstable cardiovascular disease, diabetes mellitus, uncontrolled hyperthyroidism, phaeochromocytoma, generalised dermatological disorders, renal or hepatic impairment. Stopping smoking may alter the metabolism of certain drugs. Keep out of reach and sight of children and dispose of with care. **Pregnancy and lactation:** Only after consulting a healthcare professional. **Side effects:** Erythema, itching, urticaria, headache, nausea, vomiting, GI discomfort, dizziness, palpitations, reversible atrial fibrillation. RRP (ex VAT): 15mg packs of 7: £9.07, 10mg packs of 7: £9.07, 5mg packs of 7: £9.07. **Legal category:** GSL. **PL holder:** Pharmacia Limited, Ramsgate Road, Sandwich, Kent. CT13 9NJ. **PL numbers:** 0032/0292, 0293, 0294. **Date of preparation:** March 2006. **References:** 1. Sachs DPL, et al. Effectiveness of a 16-hour transdermal nicotine patch in a medical practice setting, without intensive group counseling. Arch Intern Med. 1993; 153: 1881-1890. 2. Johansson C-J. Pharmacokinetics of a 16-hour transdermal nicotine patch. Clin Drug Invest. 1996;12:198-206. 3. Pfizer Consumer Healthcare. Data on file. **Date of preparation:** December 2006. D1870

for every cigarette, there's a nicorette

Spot On launch for animal pharmacy

Frontline Spot On is making its debut on pharmacy shelves this month. Traditionally sold by vets, the flea treatment for cats and dogs was recently reclassified as NFA-VPS, meaning it can now be sold through pharmacies.

The product is supplied in pipette format and kills adult fleas within 24 hours of application to the animal's neck. It is also effective against lice and ticks and remains active for up to a month.

With a 37 per cent value market share (GFK veterinary market sales data, November 2006) and retail sales of £30 million, the manufacturer Merial hopes the wider distribution of Spot On will aid compliance among pet owners.

Supporting the launch, trade advertising is under way. A national television campaign kicks off in April, reinforced by press advertising and sponsorship activity at Crufts and other animal shows.

Point of sale and training materials for pharmacy staff are available.

Price: from £15.39 (cat, three pipettes) to £44.73 (large dog, six)

Product info:
Merial Animal Health
Tel: 01279 775858
www.merial.com

A'Biotica is your friend

A buy one get one free promotion is running for A'Biotica Probiotic from Wren Laboratories. Part of the Dtecta range, A'Biotica is designed for patients taking antibiotics to help maintain immunity and a healthy digestion during and after the course of medication. Each capsule contains at least two billion friendly bacteria, says Wren.

Product info:
Medipharma
Tel: 01264 339770
www.dtecta.co.uk

Products in brief

Fatbusting launch

Slimmer's Formula is a new weight loss product from Cellfood. Said to increase the body's metabolic rate, the product helps turn fat into muscle, claims the company.
Price: £35/118ml
HeavenEarth, tel: 01291 689676

New moniker for old

Daktarin Aktiv is the new name for the Daktarin Dual Action athlete's foot range. The change is intended to give the brand greater consumer appeal and convey its strong efficacy message, says McNeil.
McNeil, tel: 01494 450778

Back by popular demand

Source Intensive Hydration Mask is now available from Ahava UK. Its previous incarnation, Mineral Beauty Mask, was dropped by Ahava when the Source range was launched three years ago. The product is said to provide nourishment to the skin and help reduce wrinkle depth.
Price: £19.95/100ml
Ahava UK, tel: 01452 864574
enquire@ahava.co.uk

Nightly facial from Dr Lewinn's

The Dr Lewinn's Private Formula skincare range has been extended with the launch of Ultra R4 Regenerative Night Cream.

Said to plump the skin in a collagen-like way, the product is applied on retiring when the skin is said to be at its most receptive.

The night cream includes extracts of the resurrection plant found in Bulgaria, which is able to survive drought conditions, appearing to come back to life when watered.

The ingredient aids the injection of moisture into the skin, leaving the complexion bright and radiant by morning, claims Dr Lewinn's.

An anti-wrinkle peptide, Matrixyl 3000, repairs the skin, improves skin tone and elasticity while a collagen peptide, palmitoyl tripeptide-3, is included in the formulation to smooth fine lines and wrinkles as an alternative to collagen injections, claims the company.

Support for the brand includes in-store training, mini replica bottle samples and PR activity.

Price: £45

Product info:
Ken Lamacraft Marketing
Tel: 01892 750888

Veet looks forward to a hair-free summer

Veet has unveiled a raft of new depilatory products. The Hair Removal Cream Pump is described as a 'mess-free' dispenser giving results in three minutes for the dry skin variant or five for sensitive.

Veet Ready to Use Wax Strips for Sensitive Skin contain vitamin E and almond oil. Said to be fast, effective and simple to use, the strips are warmed in the hands before use.

For more delicate areas, bikini and underarm wax strips have been introduced, providing hair-free results for up to a month, says Veet.

Completing the line-up is the new Skin-caring range. In-Shower cream, 3 Minute cream and the Rasera bladeless kit have been reformulated to include shea butter and lily petals for dry skin, lotus milk and jasmine for normal skin and wheatgerm oil and orchid for sensitive skin.

Price: pump £9.99/400ml; strips £5.99/20; bikini & underarm strips £5.49/16

Product info:
Reckitt Benckiser
Tel: 01793 732000

Men, b: prepared for stylish hair

Brylcreem says it is going back to basics with the launch of the b: hairstyling range for men.

There are six products in the range, presented in simple packaging with a five-point scale highlighting strength and hold qualities. For short to medium length hair, Texturising Gum is suitable for choppy, messed-up styles while Remoulding Paste gives reworkable style, says Brylcreem.

For short hair, Styling Wax gives texture and definition without shine and Styling Clay provides a matte effect. Two gel products – Endurance and Natural Look – complete the b: line-up.

Price: £3.49
Pip codes: Gum 32S-3168; Paste 32S-3135; Wax 32S-3143; Clay 32S-31S0; Endurance 32S-3127; Natural Look 32S-3119

Product info:
Sara Lee Household & Bodycare
Tel: 017S3 523971

Products advertised on TV next week

Astral: five, GMTV, Sat
Bio-Oil: All areas except LWT and GMTV
Buscopan: C4, five, GMTV, Sat
Covonia: five, GMTV, Sat
Cura-Heat Irritable Bowel Syndrome: C4, GMTV, Sat
Cura-Heat Period Pain: C4, GMTV, Sat
DulcoEase: C4, five, GMTV, Sat
Gaviscon Double Action: All areas
Lucozade Sport: Sat
Lyclear Spray Away: GMTV, Sat
Milton: All areas except five
Multibionta Activate: Y, C, A, CTV, W, M, LWT, CAR, GMTV, Sat
Sensodyne Base: All areas
Sensodyne Pronamel: All areas
Seven Seas Cod Liver Oil: GTV, GMTV, Sat
PharmaSite for next week: Ibuleve – Windows, **Ibuleve –** In-store, **Otex –** Dispensary
Pharmacy channel: Vega Nutritionals, Day & Night Nurse capsules, Aveeno

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Products in brief

Gadgets and gizmos

Energizer is lead sponsor for the latest series of the Gadget Show. The opening and closing credits and bump breakers feature a young inventor pitching new ideas for gadgets to his boss.

Brand icon Mr Energizer is seen catching an Ultimate Lithium battery with the strapline 'Energizer Ultimate Lithium, for today's high tech gadgets'.

The channel five show runs for 10 weeks at 7.15pm on Mondays.
Jenks Sales Brokers
Tel: 01844 293600

Heinz boost for babies

Heinz is relaunching its Farley's Rusks and Cereals ranges with improved nutritional content. Prebiotics, vitamins and minerals are being added to Farley's Rusks. Two new flavours – peach yoghurt and baby rice & banana – join the Breakfast and First Food lines. Packaging has been redesigned. Price: £1.89. Pip codes: peach yoghurt 32S-2913; baby rice & banana 32S-290S.
Heinz, tel: 020 8S73 77S7

Slowly does it

A range of thickened drinks has been launched by SLÕ Drinks.

Designed to hydrate patients suffering from dysphagia, the drinks were developed in consultation with clinicians and the NHS.

Presented as individual one-shot drinks, pre-dosed with thickener and flavouring, the drinks are made by adding water to a dotted line and stirring to give a 11Sml drink.

Coloured cups identify the consistency of the finished drink which match the National Descriptors 2002, virtually eliminating the risk of providing an incorrect consistency, it is claimed.

Lemon, orange, peach, blackcurrant and peach flavoured cold drinks are available, together with hot lemon tea, white and black coffee and hot chocolate.

Cold variants are available on prescription. They come in plastic sleeves of 2S with stirrers and instructions, or cases of 150.

Price: £7.S0/2S
SLÕ Drinks
Tel: 0845 222 220S

Partners in **crime?**

David Reissner reports on what happened the day an inspector called...


Bethany Straker

Our clients – both pharmacists – own a business in partnership. One of them (A) ran the pharmacy. The other (B) only did an occasional day there. Pharmacist A engaged a locum for a day. A series of unforeseen events then occurred. The locum dispensed a CD for an addict who did not turn up to collect it. The locum took the patient's address from the PMR instead of the prescription form, but the patient had recently moved. The pharmacy did not deliver to addicts but somehow the dispensed item got into a box of items to be delivered. The delivery driver had written instructions to bring back to the pharmacy any medicines he had not delivered into the hands of a patient or carer, although it was not the practice of the pharmacy to require medicines to be signed for (which the RPSGB service specification insists on).

The driver was in a hurry and when he got no reply at the door of the patient's former home, he put the item – methadone – through the letterbox. The new occupier took the methadone to another pharmacy, and the matter was reported to the RPSGB.

When the inspector called at our clients' pharmacy, she found some unsigned repeat prescriptions that pharmacist A had dispensed a few weeks earlier. Pharmacist A had been asked to do so by the surgery staff who were under pressure just after a bank holiday, with the regular GP away and her locum having left on a home visit without signing the forms. Pharmacist A agreed because he did not want to delay patients receiving their medicines. Supplying POMs against unsigned scripts (they were not repeatable prescriptions) is an offence under the Medicines Act.

The RPSGB made a complaint about both partners to the Statutory Committee. They alleged they were guilty of misconduct because of the supply through the letterbox, failing to apologise to the new occupier of the patient's former address, and supplying POMs against unsigned prescriptions. We acted for both partners (having been asked by them to take the case over from separate firms of solicitors originally instructed on their behalf).

> "When he got no reply, he put the item – methadone – through the letterbox"

The Statutory Committee accepted our argument that the delivery of methadone through a letterbox was not misconduct in this case: the chain of events had been triggered by a locum printing an address label based on the old address in the PMR, rather than taking the new address from the prescription form (there was no complaint of misconduct against the locum). The Statutory Committee rejected an allegation that it was misconduct by our clients not to have put the new address in the PMR – the prescription dispensed by the locum was the first one to show the patient's new address.

The Code of Ethics requires pharmacists to apologise to patients when an error is made. However, the occupier of the patient's former address was not a patient. We pointed out that the occupier had not complained. In any event, there was a practical problem: the inspector had not told our clients the name of the occupier, and they did not know her telephone number. The pharmacy at which the methadone had been handed in could not have provided the occupier's details from its PMR because this would have breached the Data Protection Act. The Statutory Committee agreed that failure to apologise to the occupier was not misconduct.

Pharmacist A was found guilty of misconduct for dispensing against unsigned scripts – but the Statutory Commission imposed the lowest penalty available: an admonition.

As for his partner, pharmacist B, we argued that a pharmacist owner was not automatically guilty of misconduct just because something had gone wrong at a pharmacy she jointly owned. Similar considerations apply to superintendent pharmacists of companies. The Society relied on a passage in the Code of Ethics that said owners (and superintendents) have personal as well as professional responsibilities. We pointed out that if the Society had its way, no-one could ever safely be a partner in a pharmacy business unless all partners worked at the pharmacy full-time – and it would not be safe to be joint owner of a business with more than one pharmacy. An owner must be able to trust another pharmacist to whom the running of a pharmacy has been delegated.

Fortunately for partners in pharmacy businesses, and for common sense, the Statutory Committee upheld our submissions and dismissed all the Society's allegations against pharmacist B.

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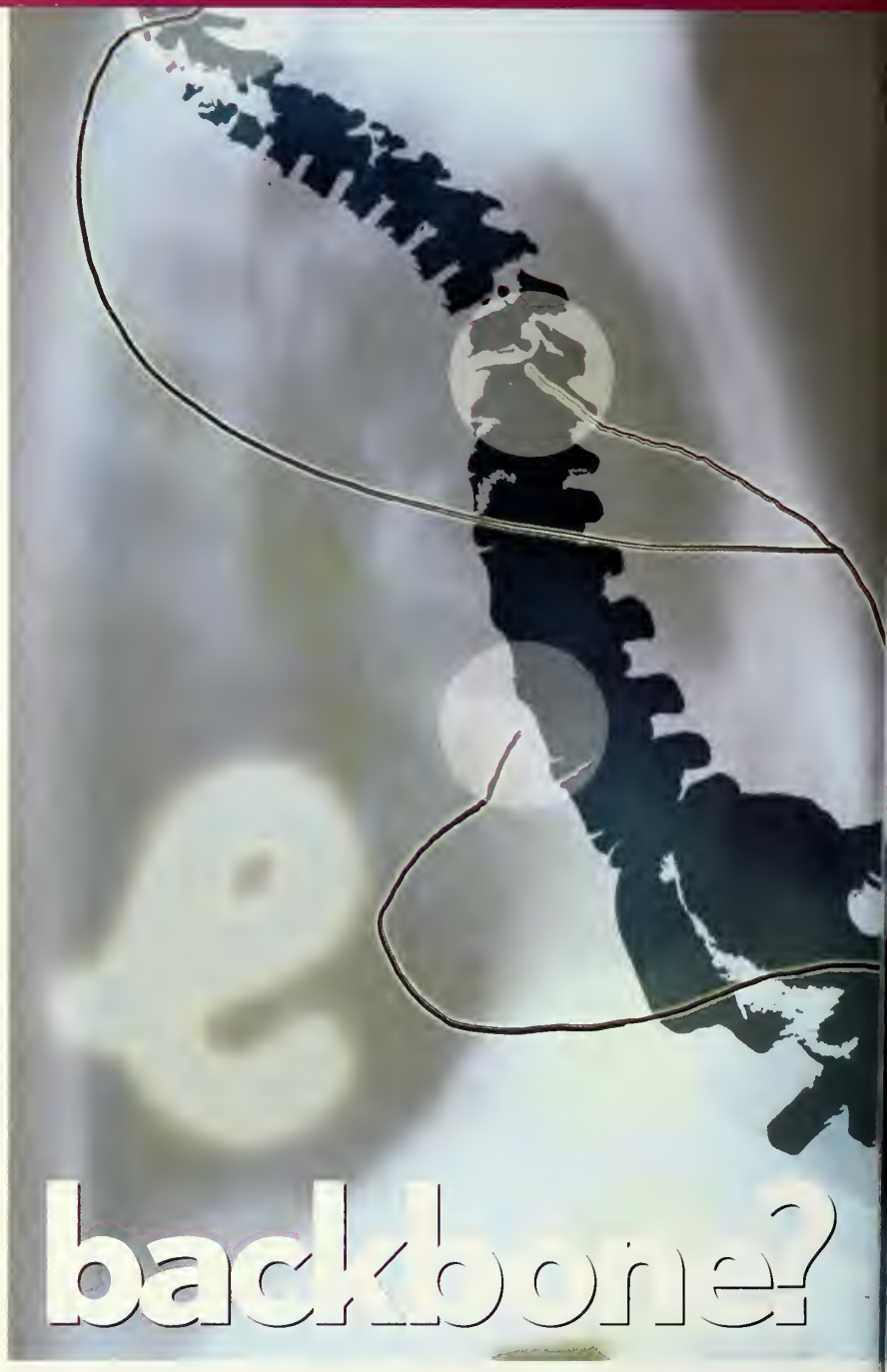

Pharmacy is on the cusp of a technological revolution – for the first time access to electronic patient records is a distinct possibility. Yet there is notable resistance, and it is coming from unlikely quarters. **Wesley Yin-Poole** investigates...

Have you got the backbone?

2007 is set to be the year an electronically connected NHS becomes a reality. It will see patient medical records become, for the first time, mobile, and not confined to the filing cabinets of GP offices.

The NHS Care Records Service (NHS CRS) is the scheme the government hopes will achieve that goal. It has been charged with storing the nation's health records on a computer database, called the spine, and developing the IT which will allow NHS staff to access it whenever and wherever they need it.

Pharmacy naturally wants a piece of the pie, allowing it to more effectively treat patients, empower its professionals and deliver on the new contracts.

And yet the idea of a pharmacist having access to medical records seems to have struck fear into the minds of the British public. In November 2006, a Guardian newspaper inquiry found "a lack of safeguards against access to the records once they are on the spine".

Pharmacists want answers too. Who will fund it? Is the information secure? Does pharmacy even need it? And what will happen if I make a mistake?

Most of the interested parties, from the NHS to pharmacy associations, are in agreement: pharmacy needs access to the NHS CRS. There are, however, lingering concerns.

"What is clear is that as the professional role expands [and as pharmacists get access to patient records] there will be a corresponding increase in risk," says NPA practice director Colette McCreedy. "Pharmacists will be expected to exercise professional discretion by factoring in all available information in the treatment of patients."

The NPA clearly sees liability as a crucial issue in the ongoing debate. Can pharmacy afford to ignore the fact that with greater rights to patient records comes greater responsibility?

"Pharmacists need guidance here," argues Ms McCreedy. "At what point do you override what a doctor says and refuse, for example, to dispense a prescription? The NPA will be making sure that any potential risks, new or existing, are dealt with in a way that is conducive to a busy pharmacy environment. And we will be seeking to do this before, rather than after, care record access becomes a reality."

The government agency in charge of implementing the NHS CRS and the ongoing rollout of the electronic prescription service (EPS) is Connecting for Health. Browsing its website, it seems the only thing holding pharmacy back is convincing the public that its medical history is safe in pharmacy's hands.

There are plenty of obvious and pressing concerns here. What's stopping a pharmacist, for example, sharing his log-in details with other staff during busy periods? Will a 12-year-old computer genius be able to hack into the system and dig out your medical history?

"The level of encryption is the same used by the CIA to pass messages around the world," argues Geoff Mackay, an independent pharmacy consultant who was involved in the implementation of EPS. "No system is 100 per cent perfect, but I would rather my records were held electronically than in a metal cabinet in some dingy GP's office."

Mr Mackay is supremely confident in the quality of the system that would be used. "Looking at the way EPS was implemented, it's the same guys," he says. "I would suggest very strongly public interest is going to keep these guys on side. These people really want to make a difference."

Pharmacists have also expressed concern over cost. "You can't expect pharmacy to pay for it," says Dr Howard Stoate MP, who is also chairman of the All-Party Pharmacy Group.

"Ultimately it's got to be PCT money. But pharmacy has got to convince the various parties that this scheme will benefit patients. If GPs can be convinced, it's much more likely to get the go ahead."

Pharmacists can expect to be caught up in the cross-fire of the debate as it is played out on the front pages of newspapers and in TV studios throughout 2007. The government, meanwhile, is

How it would work

The information on the NHS CRS will be stored at two levels: detailed records, which will be held locally at the point of care delivery, and essential information, which will be uploaded to a summary record (part of the spine). This summary record will contain personal details and important care information of relevance to other healthcare professionals.

Staff working in pharmacies will only be able to access patient's records if this is necessary as part of their role. This means that in most pharmacies it will only be the pharmacist and the dispensing technicians who access a record when dispensing or counselling a patient.

The computer from which the record will be accessed must be in an area that cannot be viewed or accessed by other staff or the public. Access to the NHS CRS will be controlled by the use of a smartcard, which will be issued to individual pharmacists after appropriate checks have been made. Pharmacists will be responsible for the safe and appropriate use of their smartcard when working in a pharmacy.

In addition, the government has suggested that patients will be able to place information that they do not wish anyone to see in a sealed envelope, which will not be able to be accessed without obtaining further consent.

Source: NPA

still a long way from rolling out the service nationwide.

This spring the NHS will begin creating the summary care record (SCR), the personalised medical history of the 50 million plus NHS patients in England. This will be available to NHS staff involved in the patient's care, anywhere in the country. SCRs will form a key part of the NHS CRS. It will, however, be several years before everyone can have one.

However, Connecting for Health says there are already plans for a pilot scheme that will enable access in one form or another to the NHS CRS. These pilots will then be evaluated before the NHS embarks on a wider rollout.

A spokesperson told C+D: "We have had a number of expressions of interest from PCTs who would like to be among the first wave of early adopters of the NHS CRS. From this list, we have formed a shortlist of sites and we are working with them to assess their suitability.

"This is work in progress and it would be up to individual PCTs to announce their involvement. The technology will be ready before we start sharing records, however there is much work that needs to be done. The DH will be consulting on what information should be available to community pharmacy through the NHS CRS and, in particular, how the information should be dependent on the role of the member of staff and the services the pharmacy has agreed to provide."

Pharmacy access to patient records: your view

"The public is concerned because it doesn't perceive pharmacy as part of the healthcare system. It's the role of professional bodies to educate. I don't think they are doing enough. My only concern is if you have access to clinical records you have increased liability for error. I would then be looking for appropriate remuneration."

Beran Patel, Brigstock Pharmacy, Thornton Heath

"You have to take time off work to see a doctor. You either change the GP system and open nine to nine or you allow pharmacists to do their job properly. Today's younger generation has grown up with electronic information and fast access. If I already do online banking why should I be worried about this?"

Alexia Adam, patient, 26, Leeds

"There will be one crooked healthcare professional who will sell the records to the tabloids and that is a problem. The smartcard won't stop illegal access. If you have a smartcard with a security chip, then it becomes a credit card, and all somebody needs to do is steal it to get access to the records."

Uma Patel, Dunn Chemist, Leeds

"It would have to be with patient consent, and the mechanism would have to sort what major medical information should be available. GPs are quite happy to accept pharmacists are part of the team. There is the feeling from some GPs that pharmacy is treading on their territory. But it's getting better year by year."

Dr Howard Stoate MP

The case for

The NPA's position paper, Community Pharmacist Access to Patient Care Records, outlined five primary reasons why pharmacists need access to patient care records:

- **To benefit patients.**
- **To prevent harm to patients.**
- **To benefit other care professionals.**
- **To carry out their responsibilities under the new contract.**
- **To benefit pharmacists themselves.**

The case against

- **The media outcry seems to be a matter of trust buoyed by a view that pharmacy is not the place where medical records should be accessible. That pharmacists and pharmacy staff cannot be trusted with patient confidentiality in a 'shop'.**
- **It is not necessary for pharmacists, who are not supplementary prescribers, to have access to anything other than their own patient medication records.**
- **It would be too expensive to include every community pharmacist in the Connecting for Health programme.**

Eurofile update

Jörn Runge reports on the effect of internet pharmacies on Danish national health insurance; Czech pharmacists fighting their corner; Austrian GPs resenting pharmacist health checks; and worries about reform in Germany

Denmark

As Brussels intensifies its efforts to ensure the compatibility of national law with European law, Danish pharmacists might face new problems. This time the EU commission is putting the supply of medicines to the test, as some say the strict rules regarding opening pharmacies are being ignored.

The point at issue is that the public health insurance system only refunds medicine costs in the form of a subsidy for products that have been purchased from pharmacies alone. Adding to the complexities is the accounting system for every insured person, which has to be managed by a pharmacy as well. As Danish customers are willing to buy medicines from European internet pharmacies to save money, the system is starting to show problems. Consumers cannot charge the national health insurance system for medicines from sources other than Danish pharmacies. The press has reported that the EU commission would investigate if these rules have to be classified as trade barriers, which ensure a national monopoly if they bar Danish consumers from purchasing medicines from internet pharmacies.

On the other hand Niels Kristensen, chairman for the Danish Pharmaceutical Association, pointed out that Danish pharmacists detect around 100,000 mistakes on prescriptions every year, an achievement, he said, that would not be expected from an internet pharmacy in Greece. A purchase abroad would cut off patients from consulting services in Danish pharmacies, he added.

Czech Republic

Once more representatives of the Czech Chamber of Pharmacists have called on pharmacists to unite as, in their view, the fragmentation of the business has already weakened the profession and pushed the liberalisation agenda. The chamber is concerned about the establishment of chains, the cut of trade margins and the release of sales prices. On top of that, Czech pharmacists are having to deal with wholesalers' fight for market share.

While Pharmos – the last national wholesaler – still holds 22 per cent, international competitors are trying very hard to gain share. Alliance UniChem especially, with a share of 19 per cent, is regarded as being particularly keen to widen its influence. Only last year the ambitious wholesaler tried to buy pharmacists' shares in Pharmos. The takeover failed because the shareholders, who number around 800, resisted, but pharmacists expect further attempts. Although the Czech arm of the company always assured the almost 2,000 independent pharmacists that there are no plans to run its own stores, pharmacists are still worried.

They argue that Alliance UniChem already runs chains in the UK, Norway, Italy and Holland. Furthermore the company holds a share in the Swiss Galenica, a wholesaler which not only develops, manufactures and markets pharmaceutical products but also runs pharmacies. As Alliance UniChem will become a second sales partner for the virtual pharmacy chain Druzstvo lékáren, which has so far worked exclusively with Pharmos, pharmacists see their fears as being confirmed.

Austria

When Austria's pharmacists performed a health check among 68,000 customers for blood pressure, diabetes, cholesterol levels, abdominal girth and weight they achieved one of the biggest risk studies of its kind in Europe. But not everybody was pleased by their efforts. Doctors throughout the country criticised the action as counterproductive; the diagnoses and therapy-like counselling interviews gave patients an illusory feeling of safety, they said.

Furthermore, they argued that the low-level interventions would contradict the health/political goals of raising people's awareness of precautionary health measures. Adding to this, the Austrian Chamber of Physicians declared that pharmacists would not have the competence and experiences to take over GPs' tasks anyway.

The Austrian Chamber of Pharmacists was taken aback by the criticism, particularly as pharmacists advised more than 30,000 participants of the study to consult a doctor regarding their results.

Pharmacists detected 1,500 diabetics while every second participant was obese, 53 per cent had high cholesterol levels and 46 per cent were hypertensive. In addition, as each pharmacy had sent staff to a training program for the screening action, pharmacists feel particularly affronted. And because the Austrian health minister Maria Rauch-Kallat had acted as patron for the health check scheme, pharmacists say the GPs' fear of competition is the main reason for their objections.

Germany

Pharmacists all over Germany joined doctors and hospital workers in December to protest against the government's plans to reform the health system once more. Under the theme 'Patients in distress – this reform harms all', they organised symposia, marches and limited services in pharmacies and GP practices to make patients and customers aware of the reform's consequences for the nation's health.

Meanwhile the ministry declared that its decision that pharmacists have to save e0.5 billion in medicine expenses will be enforced. Pharmacists could do without parts of their margins from health insurance payments and should try to exempt patients from some of their additional payments. Last but not least, pharmacists should negotiate rebates with the pharmaceutical industry, says the government. But many pharmacists complain that a new law introduced in May 2006 would ban this kind of negotiating. Furthermore they argue that the number of supplied packages in 2006 dropped 0.7 per cent. This alone saved the health insurance organisations' costs of around e138 million.

Altogether there will be a stagnation of expenses for medicines for the public health insurance organisations in 2006, which pharmacists would like to be taken into consideration. Meanwhile, pharmacists' representatives warned colleagues against entering into a price war as it would only damage their reputation, harm businesses and affect the service to patients and customers.

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Not quite a Triumph

Bon Viveur

Once proud and powerful but now unlovely and unimpressive, Coventry lies in mute testimony to the intransigence of trade unions and the failure of successive governments' industrial policies in the 1950s and 1960s. Once it was a vibrant centre of the British car industry, home to such evocative names as Lea Francis, Armstrong Siddeley, Alvis, Humber, Daimler, Riley, Triumph and many more.

One of the best known was Standard Motors, run for 24 years by a titan of British pre and post war industry, Sir John Black, before it eventually disappeared into the maw that was British Leyland.

Sir John joined Standard in 1924 and around the same time expressed his position and wealth in the building of a fine Lutyens style manor house in the Warwickshire countryside. Today that house is the Mallory Court Hotel and Restaurant and myself and the New Blonde (NB hereafter) decided we would honour it with our presence for dinner.

The exterior and fountain court have been ruined by the addition of a conference wing but the rear and gardens still evoke a past age of wealth and privilege. Inside, the cosy, chintzy, log fire-burning reception rooms and oak panelled dining room are warm and welcoming.

> My roulade of quail, black pudding and celeriac was a complicated confection of many ingredients...

Unfortunately this was not the case with the staff. There were no menus to give us when we arrived, the service throughout was surly (with the notable exception of the extrovert sommelier), and it was necessary to scour the hotel to find someone to take our payment; but I digress.

After the usual amuse bouche (a fried crab ball being the best) we chose from the more extensive of the two fixed price menus (at £55 per head).

NB's starter of scallops on a cauliflower purée with curry foam was excellent but my roulade of quail, black pudding and celeriac was a complicated confection of many ingredients, none of which seemed to go together.

This was followed by sea bass with fennel and many other unidentifiable vegetables thrown together on a plate and my loin of veal with sweetbreads was spoiled by the chef's urge to put a small piece of every vegetable he had in the kitchen into the pan.

If there is a school of cookery that holds that the more complex the dish, the more julienne of vegetables that can be added to it and the more the key ingredients can be disguised, then Mallory Court's Michelin-starred Simon Haigh is its high priest. Good cooking should let the ingredients speak for themselves and should let subtle combinations add to a dish's savour. Complexity for the sake of it may look pretty but does not advance the gustatory pleasure.

From an extensive wine list we drank a 2001 La Croix de Beaucaillou, the second wine of Ducru Beaucaillou (a 1967, of which I drank over Christmas, to my great pleasure) which was excellent – blackcurrant and leather notes to the fore. To go with our cheese selection the sommelier recommended a Chateau Moulin Pey-Labrie 2000 which was, frankly, awful and lost him many brownie points.

I've eaten at this hotel over many years but I regret I do not believe that the cooking now is as enjoyable as when the late Alan Holland or Steve Love were cooking here, and at £241 (excluding service), the bill was not lightweight.

Would I go here again?
Probably not – I don't think this restaurant merits the price or the reputation.

What would I change?
Lovely place, shame about the staff!

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